OLA HOU CLINIC PATIENT INTAKE FORM

Directions: Please fill out this form as completely as possible, both front and back sides. Please print. Information will be kept confidential. Thank you for your time and attention.

IDENTIFYING INFORMATION

Patient's Full Name:
Address:
City / State / Zip:
Date of Birth:
Social Security #:
Marital Status:
Ethnic Background:
Religion:

CONTACT INFORMATION

Provide all numbers where you might be reached.

Home Phone #:
Work Phone #:
Cell Phone #:
E-Mail Address:

INSURANCE INFORMATION:

If more than one insurance, please give information for both.

Insurance Company: 1.	2.
Subscriber #:	
Plan #:	
Group #:	
Date Plan Started:	

IF INSURANCE IS UNDER SOMEONE ELSE'S NAME

Skip if insurance is in your name.

Subscriber's Name:
Date of Birth:
Social Security #:
Employer:
Subscriber Phone #:

ACCIDENT / INJURY INSURANCE INFORMATION

Fill out if using No Fault or Worker's Compensation Insurance.

Insurance Type:
Insurance Company:
Adjuster's Name:
Claim / Case / File #:
Date of Injury:

REFERRAL INFORMATION

Who recommended you to Ola Hou Clinic?

Name:
Agency:
Address:
City / State / Zip:
Phone Number:
Okay For Us To Send Them A Thank You Note? ☐ YES ☐ NO

PLEASE CONTINUE THIS PATIENT INTAKE FORM ON THE OTHER SIDE

OLA HOU CLINIC PATIENT INTAKE FORM CONTINUED

LIST EVERYONE LIVING WITH YOU (THE PATIENT)

Name:	1.	2.
Relationship to You:		
Date of Birth:		
Name:	3.	4.
Relationship to You:		
Date of Birth:		
Name:	5.	6.
Relationship to You:		
Date of Birth:		
Name:	7.	8.
Relationship to You:		
Date of Birth:		
Name:	9.	10.
Relationship to You:		
Date of Birth:		

CURRENT EMPLOYMENT OR EDUCATION INFORMATION

If more than one job, or job plus school, then please give information for both.

Company / School:	1.	2.
Address:		
City / State / Zip:		
Position / Major:		
Full or Part-Time?		
Date Began:		

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

Name & Degree:	
Medical Center:	
Address:	
City / State / Zip:	
Phone #:	

PREVIOUS COUNSELOR

List who was the last psychologist, psychiatrist, or other mental health professional you saw.

Name & Degree:	
Agency:	
Address:	
City / State / Zip:	
Phone #:	
When (From / To):	

SIGNATURE

I will abide to all the policies in the Ola Hou Clinic Patient Information Handout. Also, if the patient is a minor, I give permission for my child to be treated:

Signed: Date: